

**Results** The project is ongoing at the time of writing, however, initial results are positive, with an increase in individualised goals being documented at each visit from 65% to 90% in the first month of the project. This will continue to be monitored to ensure practice is embedded.

**Conclusion** This project, being driven by a team member passionate about goal-setting with patients, coupled with explaining why the practice is important from the perspective of the regulator, have helped to achieve buy-in from the team.

**P-84 IMPROVING COMMUNICATION OF PATIENTS' PREFERENCES REGARDING HOSPITAL READMISSION – A QUALITY IMPROVEMENT PROJECT**

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**Background** Hospital re-admissions often contribute to unnecessary suffering and decreased quality of life for palliative care patients and their family members, particularly those approaching the end of life. Discharge summaries provide vital information to support healthcare professionals when making decisions about care settings and whether patients should be re-admitted to hospital. A baseline audit of hospice discharge summaries conducted between October 2022 and March 2023 found only 15% of discharge summaries contained information regarding patients' preferences for hospice or hospital readmission.

**Aim** To improve communication between healthcare professionals regarding patients' preferences for place and ceilings of care.

**Methods** A quality improvement project was conducted. The hospice discharge summary template was updated to include a specific section on 'patient's preferences regarding hospital admission'. Medical staff were updated about the changes and teaching provided to key members of staff regularly involved in writing discharge letters. A review of discharge summaries between April 2023 and May 2023 evaluated the impact of these changes.

**Results** Documentation of patients' preferences for hospital admission improved 56% (15% (3/20) to 71% (5/7)) following the changes implemented. Information included in the most recent discharge summaries were that two patients would be for hospital admission, two were not for readmission and one patient had declined to discuss admission.

**Conclusion** We found an improvement in the documentation of patients' preferences for hospital admission following changes made to our discharge template document. Reviewing and changing template documents can have important effects of the quality of information provided between care settings. Further audit and quality improvement cycles are planned.

**P-85 EVALUATING THE QUALITY AND EFFECTIVENESS OF GP UPDATE LETTERS BETWEEN A SPECIALIST COMMUNITY PALLIATIVE CARE SERVICE AND GENERAL PRACTITIONERS**

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**Background** Accurate and timely communication between primary and secondary care is essential for delivering high-quality patient care (Dinsdale, Hannigan, O'Connor et al. *Fam Pract.* 2020; 37(1):63–68). Communication and collaboration between primary care and palliative care providers is needed to deliver complex care management and to coordinate care, and letters form an important modality for this (Professional Record Standards Body. *Outpatient letter v2.1.* [internet]). There is increasing evidence that GPs prefer to receive structured clinic letters from specialists, with clearly communicated problem lists and outcomes.

**Aims** To assess the effectiveness of GP update letters in communicating key messages and outcomes of a patient encounter with the specialist community palliative care team.

**Methods** To evaluate our template based GP update letters over a period of two months, assessing accuracy, timeliness, and clear conveyance of key messages including recording:

- Specific problem(s) for which the specialist team are offering advice.
- Investigations and change of management plan.
- Rationale for medication changes and prescription requests.
- Controlled medication requests given specific doses.
- Actions requested of General Practitioners in clear courteous manner, including urgency of action.

**Results** Interim data at two weeks: 37 letters sent. 86% sent same day. 100% recorded primary diagnoses. 37% recorded secondary diagnoses. 89% clearly outline relevant problems. 87% made a clear prescription request. 19% of letters requesting controlled medications did not specify doses.

**Conclusion** Interim analysis shows GP update letters were sent within 48 hours. Areas of improvement could include recording secondary diagnoses, further clarity around specific problems such as problem listing, and prescription requests, which for controlled drugs suggest doses. This ongoing audit is concurrent with further enquiry of the GP view via survey, and assessing an opportunity for letter writing training for the wider multi-disciplinary team, also by survey of confidence. Adding to the template format may assist these improvements.

## Digital ways of working

**P-86 DIGITAL LEGACY AND PALLIATIVE CARE: USING TECHNOLOGY, DESIGN AND HEALTHCARE PARTNERSHIPS TO RESEARCH HOW DIGITAL INFORMATION IS MANAGED AFTER DEATH**

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**Background** Research, using design and digital methods, can potentially help patients and caregivers to manage their digital legacy (the digital information available about someone following their death – Coop, Marlow. *Palliat Med.* 2019;33(1):114–15). However, there is a lack of multi-disciplinary partnerships needed to conduct digital legacy research in palliative care (Nwosu, McGlinchey, Sanders, et al. *JMIR Aging.*

2022; 5(1):e32075; Nwosu, Collins, Mason. *Palliat Med.* 2018; 32(1):164–66). Multidisciplinary partnerships involving design, digital and palliative care stakeholders can potentially improve the conduct of digital legacy research to improve outcomes for patients, caregivers and wider society (DeSanto-Madeya, Tjia, Fitch, et al. *Am J Hosp Palliat Med.* 2020; 1049909120971569).

**Aim** To develop a multidisciplinary digital legacy design network (comprising of palliative care, digital and design stakeholders) to work collaboratively to improve the capacity to conduct digital legacy research.

**Methods** This study is funded by the National Institute for Health and Care Research (NIHR), North West Coast Clinical Research Network. Over 12 months, we will conduct a number of engagement activities to facilitate connection with stakeholders (e.g., palliative care, digital and design stakeholders). Planned activities include two face-to-face conferences and regular online meetings. Stakeholders will work collaboratively across the following work-packages: (1) role of new technologies in digital legacy, (2) role of design in digital legacy, and (3) inequalities and inequity in digital legacy.

**Results/anticipated outputs** NIHR Funding has been secured and planning is in progress. Anticipated outputs include: (1) closer collaborative working of multidisciplinary stakeholders, leading to innovation, co-creation and generation of mutually beneficial outcomes for patients, staff and services, and (2) development of research funded studies, originating from the work-packages, to provide evidence for how patients, caregivers and wider society can be supported to manage their digital legacy.

**Conclusion** Our vision is that this activity will develop a model that can be translated to other settings, which will demonstrate how multidisciplinary stakeholders can work collaboratively, to improve delivery of digital legacy palliative care research.

#### P-87 PALLIATIVE CRISIS: HANDS ON CARE IN A VIRTUAL WORLD

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**Background** Compton Care's clinical strategy (2022 – 2025) identifies the need for responsive services to prevent crisis escalation, avoid hospital admissions and to support hospital discharges. Our community Rapid Response service leads on individualised specialist end of life care for those patients in the last days to weeks of life. We work collaboratively with hospital specialist palliative care and community-based teams supporting patients in their own homes ensuring holistic, person-centred care is delivered, symptoms are managed, and families supported 24 hours, 7 days a week.

The national virtual ward model allows for patients to remain in the place they call home supported virtually through technology, to be appropriately stepped up or down to an appropriate healthcare setting. We have recognised that our red and amber Gold Standards Framework (GSF) patients need a more hands-on approach in a crisis. Our high intensity virtual ward was launched in April 2023.

**Methods** We retrospectively scrutinised the first month's data to evaluate the development of this service.

**Results** The initial data from April has been analysed. 52 patients were admitted. 45 admissions to hospital were successfully averted appropriately following input from our Rapid Response team. Three patients had appropriate step up to hospital in line with their ReSPECT plan. Four patients were admitted to the hospice to achieve their desired preferred place of care and death (PPC/D) and a further 10 patients were supported to die in their PPD. At the time of presentation we will have more data.

**Conclusions** Initial data demonstrates that this high intensity virtual ward model has successfully averted unnecessary hospital escalation and facilitated early discharge through timely collaborative intervention at a time of crisis and has resulted in more patients being managed appropriately in their PPC/D. This further reduces pressures on acute services.

#### P-88 PALLIATIVE CARE VIRTUAL WARD

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**Background** The purpose of the palliative care Virtual Ward is to provide safe care in the patient's usual place of residence. The aim is to avoid admission into acute hospitals where appropriate or support faster discharges back home. This will be facilitated using face-to-face visits and the use of digital technology, supported by a multi-disciplinary team.

**Aims** To offer a flexible and responsive service providing 10 virtual ward beds, to improve patient experience by supporting people in their preferred place of care and death.

**Methods** A Standard Operating Procedure was produced and shared internally and externally to consider an unmet need within the community. New posts have been created and recruited to, developing opportunities and education within the existing hospice services. Initial pilot January-March 2023, maximum two patients via internal referrals. Following the pilot, the Virtual Ward was opened in April, accepting referrals who meet the criteria. The service has produced information leaflets and posters to inform and advertise. A dedicated telephone number is supported 24/7.

**Results** The feedback has been positive, patients reported feeling supported, content to remain at home, symptoms well managed with a responsive service. All patients have avoided acute admission, supporting patients in their preferred place of care and death. The outcomes are measured and collected through SystemOne, with a quarterly report including patient and professional feedback. This has been enabled by successfully collaborating with wider community teams to improve communication and joined up care. Evidence and activity collected fortnightly submitted to NHS England.

**Next steps** The qualitative data shows improved patient outcomes to provide a responsive, inclusive, joined-up approach for our palliative and end of life care patients. The intention would be that quantitative data would evidence cost effectiveness to avoid acute admissions to support patients' wishes.